JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

REPORT TO THE GENERAL ASSEMBLY OF NORTH CAROLINA

January 2005

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January 26, 2005

TO THE MEMBERS OF THE 2005 GENERAL ASSEMBLY

Pursuant to Session Law 2000-83, House Bill 1519 of the North Carolina General Statutes, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services submits its report to the 2005 General Assembly for the 2005 Regular Session.

Respectfully submitted,

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PART I

INTRODUCTION

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is submitting this report to update the 2005 General Assembly on the activities of the LOC during the 2004 interim. Included in this report is the final report on the Plan for Mental Health System Reform as required by Section 3(e)(4) of House Bill 1519, Session Law 2000-83 (See Appendix I); a report on the findings and recommendations for the Alcohol Drug Education Traffic School Program (ADETS) as required by Section 4 of House Bill 1356, Session Law 2004-197 (See Appendix II); and the proceedings of meetings concerning the integration of care for children with multiple service needs as directed by Section 24.2 of Senate Bill 1152, Session Law 2004-161 (See Appendix IV).

The LOC met on September 29, 2004, November 17, 2004, December 17, 2004, January 4, 2005, and January 18, 2005. The DWI/ADETS Advisory Committee met on October 19, 2004, December 14, 2004, and January 4, 2005. The Children's Services Work Group met on November 17, 2004, December 7, 2004, December 16, 2004, January 4, 2005, and January 18, 2005. Committee proceedings are included in this report.

LEGISLATIVE OVERSIGHT COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services met on five occasions during the 2004 interim. The following is a brief summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting is available in the Legislative Library.

September 29, 2004

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened its first meeting of the interim on Wednesday, September 29, 2004 at 10:00 A.M. in Room 544 of the Legislative Office Building.

Kory Goldsmith, Staff Attorney, provided a presentation of enacted legislation concerning Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS) issues from the 2004 Session including two bills previously recommended by the LOC: Involuntary Commitment Warrant Clarification and Increase Fees/Qualifications for the DWI Assessments. She also reviewed the studies assigned to the Committee including a study on the Integration of Care for Children with Multiple System Service Needs. She also noted that the Department of Health and Human Services had been directed to study Care for the Mentally Ill in Long Term Care Facilities and the Financing of MH/DD/SA Services.

Jim Klingler, Fiscal Analyst, reviewed the budget provisions from H.B. 1414 – Appropriations Act of 2004 and noted items reduced or funded in the Money Report. He also noted an appropriation of $10 million to the Mental Health Trust Fund for the purpose of building community capacity and assisting with the mental health reform transition as well as changes in Medicaid policy that allow independent providers to directly enroll with Medicaid for reimbursement for services delivered primarily to non-target populations. Under Special Provisions, Mr. Klingler highlighted the Mental Health Treatment Courts item, which established three pilot mental health treatment courts in three districts.

Kory Goldsmith continued the presentation with a historical overview of mental health reform and the requirements of reform legislation. Ms. Goldsmith reviewed the State and federal context and the General Assembly's response, which included commissioning several studies. In 2000, the General Assembly created the LOC to develop a plan for mental health reform and examine ongoing system-wide issues. Ms. Goldsmith then reviewed HB 381, the reform legislation noting the significant changes in governance at the local level and the State's responsibilities.

Jim Klingler completed the presentation by summarizing what has occurred with reform implementation and identifying the work that remains to be done. He reviewed the *State Plan - Blueprint for Change* developed by DHHS. He explained the steps in creating the Local Management Entities and the Consumer and Family Advisory Councils. He noted that the Consumer Advocacy Program created in HB 381 has never been funded. However, the Division has established the Advocacy and Consumer Services Section.

million in recurring funds had been transferred from the State hospitals' budgets to the LMEs to fund community mental health services.

Addressing admissions, Mr. Moseley said the attempt to downsize 36 beds by 2005 is offset by an increase in the number of acute care adult admissions. He reviewed data addressing the reasons for the increase and said the Secretary is working with the Hospital Association to try to increase incentives for private hospitals to keep their existing psychiatric beds and to create additional beds.

November 17, 2004

The LOC held its second meeting of the interim on November 17, 2004 at 1:00 P.M. in Room 544 of the Legislative Office Building.

Senator Martin Nesbitt, Co-Chair, gave an update on the Children's Services Work Group informal information session that took place earlier that day. He told members that all the agencies representing children's services were present to discuss collaboration.

Representative Alexander, Co-Chair of the DWI/ADET Advisory Committee, gave a brief report on activities of the committee. She said the committee is studying ADET facilities and the fee structure as directed by legislation passed last Session.

Jim Klingler, Fiscal Analyst, gave an overview of the budget for community mental health, developmental disabilities, and substance abuse services and the allocation of State appropriations. He told members that of the $1.6 billion in the State's MHDDSAS budget, Medicaid pays 65% of all services delivered in the community. The State appropriates 20% of that amount. He said that just over $1 billion flows through the area programs with 49% coming from Medicaid. The difference is that the Medicaid funds are paid to direct enrolled Medicaid providers. Given proposed changes to the State Plan, all Medicaid providers will be direct enrolled which will cause significantly more money to flow from the State and the State Medicaid Program to providers and not through the area programs.

Continuing, Mr. Klingler stated that the greatest change in the budget figures had been in the growth of Medicaid payment for services (122%) over the past five years. Mike Moseley, DMH Director, added that in addition to residential treatment services, community based services are a source of growth in the Medicaid program. The issue spawned a number of questions regarding the use and regulation of group homes. Mr. Moseley said Secretary Hooker Odom is overseeing the effort to review the regulatory climate connected to these programs and other residential programs and provider qualifications.

Returning to the funding allocation presentation, Mr. Klingler reviewed the direct State appropriations to the area programs for the delivery of services. He noted that State appropriations are the main source of funding for indigent care and services not covered by Medicaid and that the funds are not equitably distributed across the area programs. Mr. Klingler said that DHHS had been instructed by the General Assembly to report by February 1, 2005 on a revised system for allocating State and federal funds to area mental health authorities.

In adult mental health, using CDC estimates, the Division believes that 260,000 people in the target population are not being served. Of those 20% to 50% are covered by insurance or alternative resources. The remaining 50% are those who should be treated by the public system. The cost would be $2,300 per case with an additional $149-$207 million needed to treat the target population.

Regarding the non-target population, Dr. Lancaster said the criteria indicates those persons may have a diagnosis of mental illness related to anxiety, underlying depression or other disorders. He said that 7% of those currently being served are in the non-target population and that approximately $11 million had been spent last year to provide services for these individuals.

Senator Dannelly briefed the committee on the DWI/ADET Advisory Committee, noting the Advisory Committee would present final recommendations to the LOC on January 18, 2005.

Mike Moseley, DMH Director, gave an update on system reform. He said that he had recently completed visits to all 15 facilities and 24 of the 33 Local Management Entities. He told members that he would complete the visits by the end of January. Mr. Moseley said the subcommittee of the Physicians Advisory Group for the Division of Medical Assistance (DMA) had made its final recommendations on the service definitions and hopefully DHHS would be able to submit the final State Plan Amendment for new services to the federal government in early January. He continued by saying that DMH had brought providers together from the various disabilities to discuss the associated rates for services. The review should be complete in early January with the final rates being published later that month. He said a comprehensive training program regarding the new service definition has been developed. Mr. Moseley said two major statewide training events are planned in January targeting providers, LMEs, and consumers.

Continuing, Mr. Moseley said a joint work group from the staff of the Division of Vocational Rehabilitation and the Division of MHDDSAS had studied the Adult Developmental Vocational Program System. The group made preliminary recommendations on developmental disabilities in August to the Division Director but the group was asked to go back and expand the scope to include consumers with mental health and substance abuse issues and to give fiscal data showing the cost of their recommendations. This process should be completed in February or March.

Regarding the Child Mental Health Plan implementation, Mr. Moseley said Dr. Lancaster is leading a group that has been working and formulating recommendations and looking at ways to ensure smooth implementation of the new services. He said one issue of particular interest is the placement of children in a residential treatment environment. Alternative treatment must be in place for those in Level 1, Level 2 and Level 3 group homes. The goal is to treat children in the home community with less disruptive, more effective and less costly services. Mr. Moseley noted that group home treatment facilities are Medicaid funded services, so any changes are subject to approval by the Centers for Medicare and Medicaid Services. The Division will present proposed rule changes to the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services at their January meeting. He also said the Secretary is finalizing a regulatory package to be presented to the Legislature during the upcoming Session.

That group will give its findings to a Division Advisory Group that will meet twice a year.

Addressing LOC member concerns, Ms. Stein explained the system requires the development of an infrastructure to support the adoption for these practices. The Area Health Education Centers and the University System are in the process of looking at the new service definitions and changing the curriculum to ensure people are prepared.

Mr. Moseley followed by adding that a major systemwide training initiative would begin at the end of January for providers, consumers, LMEs, and family members. Beyond that, a support structure will be in place to offer support as the transition begins and will continue after the new services are implemented.

January 18, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services held its fifth meeting on January 18, 2004 at 10:30 A.M. in Room 643 of the Legislative Office Building.

Andy Wilson, DMA Senior Eligibility Policy Consultant, provided an update on the policy of suspending Medicaid enrollment for persons committed to institutions. Mr. Wilson explained that the current DMA policy terminates Medicaid services for a person entering a public institution or a person between the ages of 22 and 64 entering an Institution for Mental Disease (IMD) and has been in place since 1978. Although the Centers for Medicare and Medicaid Services (CMS) recently recommended a suspension of services rather than a termination, DMA does not believe the recommendation warrants changing the current policy. Mr. Wilson explained that from DMA's perspective, the Medicaid status for persons in a public institution or an IMD is the same whether terminated or suspended. He further explained the process for reapplication upon discharge, noting the re-evaluation process would take no longer than 45 days. LOC members asked DMA to report back with a plan to shorten the review process and to provide federal and State definitions for "suspension" and "termination."

Mr. Wilson reported on multiple eligibility and waiver options under Medicaid that the State currently does not utilize. He gave 5 examples – TEFRA Children, Medicaid Coverage of the Working Disabled (Medicaid Buy-In), State/County Special assistance for Adults Living at Home, Optional Targeted Low Income Children, and Presumptive Eligibility of Children. The actual cost for incorporating any of these options has not been determined. None of the options would expand coverage to individuals over 20 years of age who are not blind; disabled; pregnant; or the caretakers of children under age 19. LOC members requested that DMA report back with an estimated cost analysis of implementing any of the options.

Coalition 2001 is a coalition representing 50 statewide not-for-profit organizations working together to meet the needs of North Carolinians living with mental illness, developmental disabilities, and the disease of addiction. The Coalition's fiscal priorities for 2005 include increasing the Mental Health Trust Fund by $20 million with an emphasis on crisis services and a recurring appropriation request of $134 million which includes $90 million for community capacity development for those in the target population who are waiting for services. The Committee endorsed the Coalition 2001

PART II

FINAL REPORT ON THE PLAN FOR MENTAL HEALTH REFORM

As required under S.L. 2000-83, Sec. 3 (e)(4)

I. Introduction

During the mid to late-1990's, North Carolina's public mental health system faced significant challenges. There were 40 Area Authorities Statewide, but several programs were experiencing severe financial difficulties and even bankruptcy. Newspaper articles chronicled deaths in State mental health facilities and State psychiatric hospitals were in danger of losing federal funds due to severe staffing shortages and record-keeping violations. The General Assembly responded by commissioning several studies (State Auditor/PCG Studies) of the State psychiatric hospitals and the Area mental health programs. The State Auditor/PCG Studies found that:

- the governance and funding structures of area authorities did not promote accountability to local governments or to the State;
- the use of State hospital inpatient beds in North Carolina was significantly higher than in peer group states;
- the accessibility and quality of clinical assessment varied widely across the State;
- services for acute substance abuse were lacking across the State;
- the role of State hospitals with regard to area programs was not clear;
- the system suffered from a lack of clarity about what it was trying to accomplish;
- the State spent a large percentage of its funds on State hospitals and clients covered under certain lawsuits, making it difficult to provide services to other individuals; and
- the State served a greater proportion of its developmentally disabled clients in large, State-operated residential centers than was the national norm and did not utilize the Medicaid waiver program to pay for community services to the extent other states did.

Contemporaneous with these studies and findings, the United States Supreme Court issued the Olmstead decision clarifying the States' responsibilities towards certain institutionalized individuals. The Court held that States have an obligation to provide community-based treatment for persons with mental disabilities when treatment officials determine that community placement is appropriate, the affected person does not oppose community-based treatment, and the placement can be reasonably accommodated taking into account available resources.

In response to these studies and court decisions, the General Assembly passed HB 1519 (S.L. 2000-83) (See Appendix I). In that legislation, the General Assembly found that:

(1) State and local governments were not effectively or efficiently using available resources to provide mental health, developmental disabilities, and substance abuse services across the State;

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems required a

III. Reform Legislation

During the 2001 Regular Session, the LOC introduced HB381 – An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level (S.L. 2001-427). In its enacted form, the legislation made significant policy changes addressing issues of State and local governance, increasing accountability, and emphasizing community-based services that are consumer driven. It established the requirement that State and local governments provide, within available resources, certain core services including: screening, assessment, referral, crisis services, service coordination, consultation, prevention, and education. It shifted the role of local public mental health, developmental disability, and substance abuse agencies from that of direct service providers to one of managing and coordinating services delivered by private providers. The legislation also established a Consumer Advocacy Program to operate at the State and local levels.[1] It also directed the LOC to conduct an in-depth review of current State funding allocation methods and disparities and make recommendations no later than May 1, 2002.[2]

The legislation also charged the Secretary of the Department of Health and Human Services (Secretary) with developing a State Plan to implement reform that included:

(1) the mission and vision for the State mental health, developmental disability, and substance abuse system;
(2) the protection of client rights and consumer involvement;
(3) the provision of services to targeted populations including criteria for targeted populations;
(4) a description of core services available to all individuals;
(5) service standards;
(6) a uniform portal process; and
(7) strategies and schedules to eliminate disparities in allocation of State funding across programs by January 1, 2007.

It also clarified the State's role as articulated in the powers and duties of the Secretary. These include:

- Review and approve local business plans;
- Oversight of area authorities, county programs and providers of public services;
- Development of a unified system of services to be provided in local programs, State facilities and private providers;
- Monitoring fiscal and administrative practices of area authorities and county programs;
- Adopting rules for enforcement of clients rights; ensuring the State Reform Plan is coordinated with Medicaid State Plan and North Carolina Health Choice; and
- Suspending funding and assuming service delivery or management functions of an area authority or county program that is not providing minimally adequate services to persons in need in a timely manner.

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[1] The General Assembly has not, to this point, appropriated the funds to implement this program.
[2] The LOC created a subcommittee to study this issue, but has not made any final recommendations to the General Assembly.

During the past four years, the Department of Health and Human Services (Department) has worked with the area and county mental health programs and other affected parties to develop and execute mental health reform.

The State Plan - G.S. 122C-102 directs the Department to develop a plan for implementing the new mental health reform law. In November 2001, the Secretary released the *State Plan 2001: a Blueprint for Change* (State Plan), which would be the central document for implementation and education regarding the future of North Carolina's mental health system. In subsequent years, the Department has updated the State Plan annually.

As directed in HB 381, the Department included in the State Plan a method for transforming the area and county mental health programs from primarily service delivery organizations to service management organizations. The State Plan created a process by which counties would decide on their form of local governance. Once established, each public community mental health program would be referred to as a Local Management Entity (LME). LME is not a statutory term, and it identifies the purpose of the public agency rather than describing its governance structure. While a county could be part of an Area Authority, a single County Program, or part of an interlocal agreement, the function of these organizations as LMEs would be the same.

Under the previous community system, area and county programs delivered a full range of services and also contracted for the delivery of services. Additionally, the area and county programs were responsible for coordinating and managing the quality and quantity of services in the community. As directed in HB 381, the State Plan set about removing these overlapping roles. LMEs were primarily intended to be management entities. Public services delivered directly by the area and county programs would be divested to private providers through the creation of qualified provider networks.

In managing services, the LMEs would be expected to perform a series of functions not previously expected of the Area and County Programs. These responsibilities include:

- Identifying the client base within each LME's catchment area;
- Understanding the need for community-based services and identifying service gaps;
- Developing a qualified provider network (now called a Provider Community);[4]
- Contracting with qualified providers;[5] and
- Approving the service plans for individual clients.[6]

Establishing the LMEs - In order to achieve this transformation from service provider to LME, the State Plan established a process and schedule for certifying newly created LMEs. This process included the statutory requirement that counties develop business plans for implementing and operating the reformed community system.

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[4] In building a network, LMEs would qualify providers that meet the State's service standards and assist providers to meet service standards, especially for newly established services.

[5] LMEs are expected to design performance contracts tied to service outcomes, and LMEs will monitor and enforce those contracts.

[6] If a service plan is approved by an LME, the LME is responsible for monitoring the client's outcomes to see if the service plan is appropriate.

CFACs, a State-level CFAC has been established to inform the Department regarding operations of the mental health, developmental disability, and substance abuse service system.

Target Populations – As a matter of policy, G.S. 122C-2 prioritizes the spending of State funds for targeted populations. The State Plan identifies and defines those targeted populations. While all citizens of North Carolina would have access to certain core services, more intensive services and supports would be made available to persons with significant and chronic needs.

Core services include screening, assessment, referral, crisis services, service coordination, consultation, prevention, and education. As implemented, these core services are also known as the Basic Benefits Package. The Enhanced Benefits Package is being developed and will move the system away from basic outpatient services to a system of intensive, home-based, cross-disciplinary, agency delivered services. The Enhanced Benefit Package will be available to those individuals who meet one or more of the target population criteria.

The use of State funds and non-Medicaid federal funds is restricted to deliver only the core/basic services to the general population and the enhanced services to the target populations. HB 381 authorizes the counties to use their funds to provide specialized services to persons who do not meet any of the target population definitions. Implementation of the target population definitions occurred July 1, 2004.

Divestiture of Services – G.S. 122C-141 no longer authorizes an area and county authority to continue as a service provider. Instead, area and county authorities are expected to contract with private and other public providers to deliver services (Qualified Provider Network). Services delivered under the new system should address the issues of access, availability of qualified private and public providers, consumer choice, and fair competition.

The State Plan directed the LMEs to include a divestiture plan in their local business plans, with the intention that divestiture of area and county authority services would occur over a number of years. While each LME is at a different stage in divestiture, the process of contracting out services is happening rapidly, and in many cases, well ahead of schedule. This rapid divestiture of services does raise the question of whether the necessary components are in place to address existing services gaps in the community. In particular, the Department is still working to implement the new array of services.

HB 381 does allow the Secretary to waive all or part of the divestiture requirements for an LME if the LME demonstrates that the divestiture of services would greatly harm access.

New Array of Services – The Department is in the process of implementing a new array of services that will comprise both the Basic Services Package and the Enhanced Services Package. The rationale behind the new service array is that the service definitions would be science-based (e.g. evidence based practices, best practices, and emerging best practices). Not only did the service need to be demonstrably effective, but effective for the defined populations that will be served in the reformed system. The process of establishing the new service array also identified and removed those services,

Assembly authorizes the financing to build those two new hospitals. The principle on any indebtedness is estimated at $166 million for both projects.

- In 2004, the General Assembly budgeted $3.5 million of Mental Health Trust Fund monies to fund the expansion of the Alcohol and Drug Abuse Treatment Centers to provide more detoxification services.

Division Reorganization – In 2001, the General Assembly directed the Department to reorganize the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (SB 1005; S.L. 2001-424). The State Plan provided guidance for the reorganization, which was completed in July 2003. The reorganization eliminated disability silos and organized the Division around function (e.g. Community Policy, State Operated Facilities, and Administrative Support). Within each Section, personnel were arranged into cross-disability teams to address operations from a broad perspective. The reorganization also reduced the number of Division sections and layers of management.

The reorganization also established the Advocacy and Consumer Services Section. The purpose of the Section is to oversee State facility advocacy, customer service, rights, and empowerment, and to communicate with local CFACs. The Section Chief reports directly to the Secretary. While the Department has implemented the Advocacy and Consumer Services Section, it has not received funding for nor implemented the Consumer Advocacy Program created in HB 381.

VI. Unfinished Business

Implementing the Service Array – Service definitions and rates have been developed, but the Medicaid State Plan amendment has not been submitted to the CMS. Assuming prompt approval by CMS, the new services will become effective July 1, 2005. Even with new services in place, the Department may still need to develop specialized services for many target population clients.

With the new service array largely designed, the Department can resume the Service Cost Model project. This project could provide the service delivery system the information needed to estimate the types and costs of services for a particular community. LMEs can soon use the new service package and cost model to begin planning the composition of their provider communities. From this work, service gaps should emerge and highlight for State leaders future policy and resource priorities. This work of assessing accurate community capacity is just beginning.

In addition to the new service array, the Department is requesting two new waivers from CMS for the Community Alternatives Program for the Mentally Retarded and Developmentally Disabled (CAP-MR/DD). The first waiver is a complete rewrite of the existing CAP-MR/DD Waiver. Among the many changes is the removal of the per person cap on funded services. The intent is to provide greater flexibility in funding service plans for individuals in the program. The second waiver, also know as the Independence Waiver, will allow consumers to manage their own services. The first CAP MR/DD waiver will be submitted in January 2005 and the Independence Waiver will be submitted a year later.

Divestiture of Services – Divestiture is happening rapidly, and the LMEs are expected to manage the divestiture in conjunction with the other processes of reform. Until the new service array is in place, many providers may be reluctant to commit to

PART III

DWI/ADETS ADVISORY COMMITTEE

The DWI/ADETS Advisory Committee was appointed by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to prepare findings and recommendations pursuant to HB 1356. HB 1356 directed the LOC to undertake a study of Alcohol and Drug Education Traffic School (ADETS) program as follows:

> "The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Services shall study the programs offered by ADETS providers to clients who must complete ADET school to receive a certification of completion of a substance abuse program. The study should include information on the qualifications of ADETS instructors, class size, the average duration of a program, the average cost of ADETS, and the adequacy of the fee paid to the ADETS provider by a client for a required ADETS course. The Committee must report its findings and any recommended legislation to the 2005 Regular Session of the 2005 General Assembly."

In September 2004, LOC Co-Chairs Senator Martin Nesbitt and Representative Verla Insko appointed Senator Charlie Dannelly and Representative Martha Alexander as Co-Chairs to the DWI/ADETS Advisory Committee. The LOC Co-Chairs also appointed Senator Austin Allran and Representative John Sauls as Committee members. Senator Nesbitt and Representative Insko appointed other committee members from a list of representative stakeholders.

The DWI/ADETS Advisory Committee convened its first meeting on October 19, 2004 and developed the scope of work and study method. With assistance of staff from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), a survey of ADETS, including a cost study, was completed in December. The DWI/ADETS Advisory Committee deliberated on the findings and made initial recommendations at its December 14, 2004 meeting, at which time the Committee also reviewed and approved the revised ADETS instructor curriculum. A draft bill was reviewed and approved on January 4, 2005 as recommendation to the LOC. A bill summary and fiscal impact analysis for the proposed legislation have been prepared and are included in this report. (See Appendix III)

METHOD OF STUDY

Currently there are 54 Alcohol and Drug Education Traffic Schools in North Carolina, serving the first offender of Driving While Impaired (DWI), with a blood alcohol content level of 0.14 or below, and substance abuse assessment not identifying a substance abuse disability.

Based on the FY 2003 data on the Certificate of Completion (DMH-508R), of a sample of 21,670 individuals who completed DWI services during 2002-2003, 23 percent of them completed the ADETS program. The program consists of s minimum of 10 hours of education, in a class no larger than 35 persons, over a 3-day period, at a fee of $75 charged to the offenders. ADETS is an educational and intervention program, and the first program beyond assessment for first-time DWI offenders.

The study is intended to address the following:
(a) ADETS instructor qualifications
(b) Class size
(c) Fee

To capture as much data as feasible within a short time frame for the study, a telephone survey was employed, using a standardized survey questionnaire. An important aspect of the study addresses the cost of services, using a cost-finding model to collect all costs associated with ADETS program. The cost findings are based on the survey model used in the 2003 study of DWI assessment fee, which included administration, personnel for conducting instructions, fixed maintenance costs, and other business-related expenses.

In addition, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has begun to revamp the ADETS curriculum, which was reviewed and endorsed by the DWI/ADETS Advisory Committee.

The Study was carried out during November 2004, and initial findings were reported to the DWI/ADETS Advisory Committee at the December meeting.

FINDINGS AND RECOMMENDATIONS

General Findings:

The telephone survey of 54 ADETS providers yielded a 93 percent response rate. Chief findings are described below:

1. Instructor qualifications:
   Out of 57 ADETS instructors surveyed and interviewed, 47 percent are certified with the North Carolina Substance Abuse Professional Certification Board (NCSAPCB). Of the remaining 53 percent, 12 have a Master's degree, 3 a Bachelor's degree, 2 are Certified Substance Abuse Counselors (CSAC) interns, 1 is CSAC, 4 have associate degrees, and 9 have a high school degree. It should be noted that the high school-degree instructors have 10 years or more experience in the substance abuse field.

2. ADETS Class size:
   There is a wide range of class sizes, from 3 to 35, with a mean at 14. Most class sizes fall in the range of 20 to 25.

3. Cost findings:
   - Current fee is $75, or $7.5 per hour.
   - Mean cost/10 hour ADETS class/15 students=$84.12
   - Median cost=$75.30
   - Range of cost from Eastern rural ($35.19) to Western rural ($126.69) showed the difference in infrastructure cost

   Other neighboring states were surveyed for comparison purposes:
   South Carolina=$500 for 16 hours
   Georgia=20 hours for $195 plus a matriculation fee of $15
   Tennessee=12 hours for a range of $75 to $125
   Florida=12 hours for $195
   West Virginia=18 hours for $250
   Virginia=20 hours for a range of $300 to $400

DWI/ADETS ADVISORY COMMITTEE PROCEEDINGS

October 19, 2004

The first DWI/ADETS Advisory Committee meeting was convened by Co-Chairs, Representative Martha Alexander and Senator Charlie Dannelly. In attendance were: Senator Charlie Dannelly, Co-Chair; Representative Martha Alexander, Co-Chair; Senator Austin Allran, Representative John Sauls, Ann Christian, Dale Kirkley, Phillip Mooring and Sandy Pearce. Offering staff support were: Dr. Alice Lin, LOC Project Manager; Spencer Clark, Michael Eisen, Jennifer Resnick and Jason Reynolds from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and Shawn Parker, Kory Goldsmith and Jim Klinger, Legislative staff and Rennie Hobby, LOC staff.

Representative Alexander described the committee as advisory in nature, providing recommendations to the Joint Oversight Committee on MHDDSAS, which may propose changes to the General Assembly. The charge to this subcommittee is to make findings and recommendations to the LOC for appropriate actions.

Dr. Lin provided an overview of the DWI subcommittee work performed in 2003 that became the genesis for this committee work. HB 1356 and its charge to the LOC to review certification requirements and fees for ADETS providers were walked through, and a scope of work for the subcommittee suggested.

Representative Alexander challenged the committee to review improved responses from the surveyed ADETS. Given the number of ADETS (54 statewide), the study approach should ensure a high response rate.

Mr. Eisen provided a summary of ADETS programs, including the criteria for students of ADETS, and curriculum of the instruction, class size, and current provider network. He emphasized the program as an early intervention program, targeting first-time offender, and is different from a treatment program where the DWI offenders have already been diagnosed as having substance abuse disorder.

Senator Allran expressed an interest in outcome studies. Mr. Eisen replied that while the 2001 data did show that intervention reduced the number of re-arrests, but there is no longitudinal data to ascertain results overtime. Mr. Clark indicated that with the increased DWI assessment fees, it would become feasible to review minimally recidivism rate.

The committee adjourned following an establishment of a timetable for the study. Two more meetings will be convened, to review preliminary findings and recommendations, and to finalize recommendations to the LOC.

December 14, 2004

DWI/ADETS Advisory Committee Co-Chair Senator Charlie Dannelly convened the meeting. Representative Martha Alexander had a schedule conflict. In attendance were Senator Charlie Dannelly, Co-Chair; Senator Austin Allran, Representative John Sauls, Ann Christian, Dr. Robert Foss, Dale Kirkley, Phillip Mooring and Sandy Pearce.

providers. Several individuals recommended a change of fee to either $150 or $160. The group settled on $160 for a minimum of 16 hours, thus rounding off the hourly rate at $10.

The effective date for new qualifications and the proposed grandfather clause were discussed. Representative Alexander referred to the DWI assessment bill as an example of dealing with the qualification issue, in that all providers are required to qualify under the new rules, but given sufficient time to come into compliance. The group adopted this approach and recommended an effective day of January 1, 2009 for compliance by all ADET providers. Spencer Clark indicated that the late effective date would not compromise the quality of the existing instruction, given the positive survey findings of instructor qualifications.

The inclusion of outcome study was discussed. Representative Alexander suggested using existing statute to incorporate the outcome study into existing quality assurance efforts by the Division.

As this is the last meeting of the Advisory Committee, the Co-Chairs thanked the members for their participation. A revised draft bill will be circulated among the members. The Co-Chairs will present the subcommittee's findings and recommendations to the Oversight Committee on January 4, 2005.

DWI /ADETS ADVISORY COMMITTEE MEMBERS

For HB 1356
Joint Legislative Oversight Committee on MH/DD/SAS
2004

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PART IV

CHILDREN'S SERVICES WORK GROUP

November 17, 2004

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened an informal information session regarding collaboration of services to children with multiple service needs on November 17, 2004, in Room 421 of the Legislative Office Building.

LOC staff gave an overview of structures for collaboration at the State Level. The Co-Chairs then received brief presentations from the State Superintendent of Public Instruction (DPI), the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), the Director of the Division of Social Services (DSS), the State Health Director (DPH), the Secretary of the Department of Juvenile Justice and Delinquency Prevention (DJJDP), and a Court Management Specialist from the Administrative Office of the Courts (AOC) regarding existing collaborative programs and barriers to collaboration.

The Co-Chairs of the State Collaborative then explained the history, makeup, and accomplishments of the organization. The State Collaborative is based on the system of care principles and provides a neutral place where those who implement programs for children can share information, receive training, and evaluate progress.

LOC staff provided an overview of three different examples of local collaboration: the Comprehensive Treatment Services Program (CTSP), which is the successor to the Willie M. Program; the Comprehensive Community Mental Health Services Program for Children and Families (a federal grant program); and the Juvenile Crime Prevention Councils.

Staff then presented the results of a survey of the local collaboratives created under the CTSP and federal grant programs. He summarized the responses to a variety of questions regarding the organizations, their commonalities, differences, and needs. The survey responses identified both positive outcomes and continued barriers to collaboration.

Chairs representing three types of local community collaboratives then spoke. Durham County Local Collaborative offered the perspective of a CTSP-established collaborative. Chatham County provided information on the federal Comprehensive Community Mental Health Services Program for Children and Families. The Wayne County Juvenile Crime Prevention Council presented the perspective of a JCPC.

The group raised several items of concern including: low attendance at meetings and agency roles. The Co-Chairs asked the participants to return in December to continue the discussions.

structure for increased collaboration. These issues included the purpose, composition, accountability, scope and scale of the structure.

Work Group members also reviewed conceptual information provided by the State Collaborative illustrating what a collaborative structure might look like including state, regional and local levels with possible functions and suggestions of what could be done at those different levels.

After a brief discussion, the consensus of the group was to recommend the creation of a Council made up of Department heads that would report to the Legislature, with subcommittees to study issues and report to the Council.

Issues suggested by the group for consideration included: legislative staff overseeing and communicating activities of various Legislative committees dealing with children's issues; annual progress report on interagency collaboration, housing the Council in the Department of Administration with staff; creation of Study Commission to look at what the Council will address; and solutions to funding.

Representative Insko ended the discussion by directing staff to prepare a bill draft and email it to the workgroup members.

January 4, 2005

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services convened the fourth meeting of the Children's Services Work Group on January 4, 2005, in Room 643 of the Legislative Office Building.

LOC staff reviewed draft legislation entitled *Council on Children, Youth and Families.* The bill draft included language stating the intent of the legislation was to improve the well being of children, youth and families, to support collaboration between Sate and local agencies, to make more effective use of resources and programs, and to streamline service delivery. The bill also recognized that services are most effective when outlined in a system of care and that even though agencies are making significant progress in collaboration and coordination of services, there is a need to focus State-level policy in order to provide support, remove barriers, and more fully implement these goals. The bill created a Council on Children, Youth and Families made of the Governor, the Chief Justice, agency heads and a parent of an at-risk child. The language does not allow for "designees" to attend Council meetings. The Council would meet on a quarterly basis to study and make recommendations on ways to improve services to children and would make annual reports to the General Assembly.

LOC staff also reviewed an alternative draft bill entitled *System of Care for Children and Families.* It would establish System of Care as State policy for the provision of services to at-risk children. The bill defined a system of care as child and family centered, strengths-based, community-based, and culturally competent. The bill provided for shared responsibilities among child-serving agencies and parameters of the creation of a system of care work group. The work group would compile information from State and local agencies and would report semi-annually to the Council on its findings and recommendations. The Council would then report to the General Assembly.

PART V

ENDORSEMENT OF COALITION 2001 PROPOSALS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services endorses the proposal offered by Coalition 2001 (See Appendix VI).

APPENDIX I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1999

SESSION LAW 2000-83
HOUSE BILL 1519

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" (Study), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the Study and other matters and to recommend the necessary changes to State law and policy; Now, therefore,

Section 1. Findings. – The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3.(a) Plan for Mental Health System Reform. – Terms Defined. – As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

(12) Consider whether the State shall implement a contested case hearings procedure for applicants and recipients of mental health, developmental disabilities, and substance abuse services.

Section 3.(d) Subcommittees. – The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the

Section 4. Oversight Committee Appointments. – The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. – On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. – This act becomes effective July 1, 2000.

In the General Assembly read three times and ratified this the 30th day of June, 2000.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ James B. Black
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 2:55 p.m. this 5th day of July, 2000

APPENDIX II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

SESSION LAW 2004-197
HOUSE BILL 1356

AN ACT TO ENACT THE RECOMMENDATIONS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO ADMINISTER SUBSTANCE ABUSE ASSESSMENTS, TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR SUBSTANCE ABUSE ASSESSMENTS, TO STUDY THE MINIMUM QUALIFICATIONS OF INDIVIDUALS CONDUCTING ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOLS, AND TO STUDY THE FEE PAID BY DWI OFFENDERS FOR EDUCATION OR TREATMENT SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

(1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

(3) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM)."

SECTION 2. G.S. 122C-142.1(b1), as enacted in Section 1 of this act, reads as rewritten:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

(1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

~~(3) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.~~

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM)."

SECTION 3. G.S. 122C-142.1(f) reads as rewritten:

APPENDIX III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RGfz-2 [v.15] (1/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/20/2005 12:15:13 PM

Short Title: ADET School/Fee/Qualis. Increase. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR ATTENDING AN ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL, TO INCREASE THE AMOUNT REMITTED FROM THE FEE BY AN AREA FACILITY TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO PROVIDE ADET SCHOOL INSTRUCTION, TO DIRECT THE COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES TO MODIFY THE RULES REGARDING THE NUMBER OF INSTRUCTIONAL HOURS AND MAXIMUM ADET SCHOOL CLASS SIZE, AND TO REQUIRE THE DEPARTMENT TO ESTABLISH AN OUTCOMES EVALUATION STUDY ON THE EFFECTIVENESS OF SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-142.1(f) reads as rewritten

"(f) Fees. – A person who has a substance abuse assessment conducted for the purpose of obtaining a certificate of completion shall pay to the assessing agency a fee of one hundred dollars ($100). A person shall pay to a ~~treatment facility or~~ school a fee of ~~seventy five dollars ($75.00).~~ one hundred sixty dollars ($160.00). A person shall pay to a treatment facility a fee of seventy-five dollars ($75.00). If the defendant is treated by an area mental health facility, G.S. 122C 146 applies after receipt of the seventy five dollar ($75.00) fee.

A facility that provides to a person who is required to obtain a certificate of completion a substance abuse assessment, an ADET school, or a substance abuse

BILL DRAFT:
ADET School/Fee/Qualifs. Increase

BILL ANALYSIS

Committee:	D.W.I./ADET Advisory Committee for Legislative Oversight Committee-MH/DD/SAS	**Introduced by:**	
		Summary by:	Kory Goldsmith, Tim Hovis Committee Counsels
Date:	January 18, 2005		
Version:	2005-RGfz-2[v.13]		

SUMMARY: ***The bill increases the fee charged for an alcohol and drug education traffic (ADET) school, increases the qualifications for certain persons providing ADET instruction, and increases the percentage of the fee remitted by an area facility to the Department to fund an ongoing outcomes evaluation study of substance abuse services. The bill also directs the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission) to revise its rules regarding the amount of ADET instructional time and maximum class size.***

CURRENT LAW: A person is guilty of impaired driving (DWI) if he or she drives a motor vehicle on any public vehicular area while under the influence of an impairing substance or with a blood alcohol concentration (BAC) of 0.08 or more. G.S. 20-138.1. Upon conviction of a DWI offense, the Department of Motor Vehicles (DMV) must immediately revoke the offender's drivers license. G.S. 20-17(a). DMV may not restore the license unless it receives a certificate of completion indicating that the offender has undergone a substance abuse assessment and either completed an ADET school or a substance abuse treatment program. G.S. 20-17.6.

An offender is eligible to attend an ADET school if the offender's substance abuse assessment does not identify a substance abuse disability, the offender has no prior DWI convictions and the offender had a BAC of 0.14 or less at the time of the offense. The fee for attending ADET school is $75. (The fee for substance abuse treatment depends upon the level and extent of treatment provided, with the minimum fee being $75.) G.S. 122C-142.1(f) and G.S. 122C-146.

The curriculum for ADET school is established by the Commission. It consists of not less than 10 hours of instruction to be delivered in class sessions that may not exceed 3 hours in length. The maximum class size is 35 persons. In order to be certified to provide ADET school instruction; a person must be a high school graduate (or equivalent); have a working knowledge of alcohol, other drugs and traffic safety issues; demonstrate skills by teaching all aspects of ADET classes; and apply to the Division of MH/DD/SAS – DWI Services for certification. 10A NCAC 27G.3801.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: January 21, 2005

TO: Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services

FROM: Jim Klingler
Fiscal Research Division

RE: 2005-RGfz-2 ADET School /Fees / Qualifications Increase

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
REVENUES					
Local Mgt. Entities	**$50,720**	**$50,720**	**$50,720**		
DMH/DD/SAS	**$57,661**	**$57,661**	**$57,661**	**$57,661**	**$57,661**
EXPENDITURES					
Local Mgt. Entities	See Assumptions and Methodology: The additional cost associated with establishing the minimum number of class hours and maximum class size could not be estimated				
DMH/DD/SAS	**$57,661**	**$57,661**	**$57,661**	**$57,661**	**$57,661**

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services and Local Management Entities

Impacts of the Fee Increase

By increasing the fee charged to DWI offenders from $75.00 to $160.00, ADET school providers will see an overall increase in revenues. These providers include 16 local management entities (LME's), which manage the delivery of community mental health, developmental disabilities, and substance abuse services. In order to determine the likely increase in revenue for the LME's, DHHS provided data on the number of persons served through LME ADET schools in FY 2003-04. Assuming that the number of ADET students remains relatively constant, the expected increase in revenue for the LME's should remain constant for the next two to three years.

This revenue increase for the LME's is affected by the current mental health system reform that DHHS is implementing. As part of reform, the LME's must divest of their direct services and contract for those services with private and other public providers. As a result, within the next three years, the 16 LME's currently providing ADET schools will need to contract for those services. This analysis assumes that revenues for the LME's providing ADET schools will remain constant until FY 2008-09, and at that time, the LME's will no longer administer the ADET schools directly. The following chart shows the estimated revenue increase for the LME's in FY 2005-06:

Increased Revenues to LME's in FY 2005-06	
Persons Served by LME's FY 2003-04	663
Current Fee per Person	$75
Proposed Fee per Person	$160
Fee Difference per Person	$85
Less the 10% Charge by DMH/DD/SAS	$76.50
Estimated Revenue Increase for LME's	**$50,720**

In addition to the revenue impact to the LME's, DMH/DD/SAS would also experience an increase in revenues. According to G.S. 122C-142.1, the Division has the authority to receive up to 5% of each fee paid by the DWI offender for ADET services. The increase in the fee will result in an increased amount of dollars remitted to DMH/DD/SAS. In addition to the fee increase, the proposed bill increases the percentage that is remitted to DMH/DD/SAS from 5% to 10%. The following chart describes the anticipated impact of the remittance and fee changes for the Division:

Increased Revenues for DMH/DD/SAS	
Persons Served in all ADETS FY 2003-04	4707
Current Fee per Person	$75.00
Estimated Current Revenue for All Providers	$353,025
Percentage Increase Remitted to DMH/DD/SAS	5%
Increased Revenue to DMH/DD/SAS for the current fee	**$17,651**
Propose Fee per Person	$160.00
Difference from Increased Fee	$85
Estimated Revenue Increase for All Providers	$400,095
Fee Percentage Remitted to DMH/DD/SAS	10%
Estimated Revenue Increase for DMH/DD/SAS from the Increased Fee	**$40,010**
Total Revenue Increase for DMH/DD/SAS	**$57,661**

APPENDIX IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

SESSION LAW 2004-161
SENATE BILL 1152

AN ACT CONCERNING STUDIES AND OTHER PURPOSES.

The General Assembly of North Carolina enacts:

PART I. TITLE

SECTION 1. This act shall be known as "The Studies Act of 2004".

. . . .

PART XXIV. JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES STUDIES

SECTION 24.1. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services may study the topics listed in this part and report its findings, together with any recommended legislation, to the 2005 General Assembly upon its convening.

SECTION 24.2. Integration of care for children with multiple system service needs (S.B. 262 – Foxx, Allran, Dannelly, Lucas, Purcell; H.B. 169 – Insko) – The Committee shall conduct a comprehensive review of the State's system of care for children with multiple system service needs. The purpose of the comprehensive review is to determine the extent to which children who need services from multiple State and local agencies in this system are or are not receiving those services in a timely manner, the effectiveness of the services provided, the potential long-term impact on the children, their families, and State and local resources of not providing all services in a timely and cost-effective manner, and to make detailed recommendations on the system changes necessary to address the problems identified as quickly as possible. Recommendations on system changes shall include programmatic and funding changes, and an analysis and estimate of implementation costs and projected cost-savings to the State in future years. In order to ensure a dedicated focus and appropriate expertise for the comprehensive review, the Committee shall convene a task force to conduct the review. The task force shall be comprised of the cochairs of the Oversight Committee, the Joint Legislative Education Oversight Committee, the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee, the Joint Legislative Health Care Oversight Committee, and other individuals appointed by the cochairs of the Oversight Committee upon recommendation of the other members of the task force.

In conducting its review, the task force shall consider thoroughly all of the following:

(1) State-of-the-art approaches to services to children with multiple system service needs as the basis of reform in North Carolina.

(2) Evidence-based best practices in North Carolina and elsewhere for potential systemwide adoption.

APPENDIX V

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U **D**

BILL DRAFT 2005-RCz-9 [v.7] (1/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/24/2005 9:58:15 AM

Short Title: Coordination of Children's Services/Study.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE COORDINATION OF SERVICES TO CHILDREN, YOUTH AND FAMILIES BY CREATING CHILDREN'S SERVICES WORK GROUPS, BY ESTABLISHING AN INDEPENDENT STUDY COMMISSION TO MAKE RECOMMENDATIONS ON HOW TO ELIMINATE BARRIERS TO COLLABORATION BETWEEN AND AMONG CHILD-SERVING AGENCIES, AND TO MAKE AN APPROPRIATION AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The General States are amended by adding a new Chapter to read:

"**Chapter 143C**

"**Coordination of Children's Services.**

"**§ 143C-1. Intent; purpose.**

It is the intent of the General Assembly to (i) improve the safety and well-being of North Carolina's children, youth and families, (ii) support collaboration between State, regional and local agencies that deliver services to children, youth and families (iii) make more effective use of existing federal, State, and local resources and programs for children, youth, and families, and (iv) streamline service delivery, fill service gaps, and eliminate duplication of services for children, youth, and families.

The Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts and other affected State agencies share responsibility and accountability to assure effective collaboration among State and local agencies to improve outcomes for children and their families leading to full participation in their communities and schools."

party receiving services and time-limited. The mechanisms may address intake, assessment and release procedures.

(6) Examine State and local training needs for implementing increased coordination and collaboration.

(7) Study other issues the work group determines would improve coordination and collaboration between child-serving agencies.

(e) A majority of the work group shall constitute a quorum for the transaction of business.

(f) Any member of the Council who is not an officer or employee of the State shall receive per diem and necessary travel and subsistence in accordance with the provisions of G.S. 138-5.

(g) Upon the approval of the Secretary of the Department of Health and Human Services, the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chair of the State Board of Education, the Superintendent of Public Instruction, and the Chief Justice of the Supreme Court, the work group shall submit its findings and recommendations to the Coordination of Children's Services Study Commission created under Section 4 of this act. The work group shall submit an interim report no later than December 15, 2005, and a final report no later than April 15, 2006. The reports shall specify those recommendations that may be implemented without statutory changes and those that would require statutory authorization.

If the General Assembly has not adjourned by those dates, or if the membership of the Study Commission has not been appointed, the work group shall submit its reports to the Joint Legislative Education Oversight Committee, the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee, the Joint Legislative Health Care Oversight Committee, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

The work group shall expire upon the filing of the final report.

SECTION 3. The Directors of the Bill Drafting, Research, and Fiscal Research Divisions of the General Assembly shall establish a children's services work group comprised of the legislative staff assigned to subject areas or agencies involving the child-serving programs administered by the Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Administrative Office of the Courts and the Department of Public Instruction.

The work group shall: (i) monitor the proceedings of the children's service work group created under Section 2 of this act; (ii) provide information to legislators and legislative bodies regarding the recommendations of the work group and methods by which the General Assembly may implement those recommendations; and (iii) provide a mechanism to improve coordination, collaboration and education regarding children's services across State and local agencies among legislative staff.

This Section shall expire upon the convening of the 2009 General Assembly. However, this shall in no way limit the Division Directors' authority to direct legislative staff to continue to implement the purposes of this Section.

and families. Once it has identified the collaborative bodies, the Commission shall consider how they could be consolidated, reorganized or eliminated in order to improve their effectiveness and accountability, increase the likelihood that key players will actively participate, and reduce unnecessary duplication of effort. The Commission shall also consider the creation of a mechanism for coordination and communication between the State and local collaborative bodies, incentives for collaboration, clarification of roles among agencies, and ways to monitor the extent to which groups are collaborating.

(2) Study the practices of agencies currently implementing a system of care platform of practices and make recommendations regarding whether to adopt those practices State-wide and across child-serving agencies as the preferred mechanism for providing services to children, youth and families. In examining this issue, the Commission shall identify those State and local agencies that are currently implementing practices that are consistent with a system of care, those States that have implemented system of care as a state-wide policy initiative, and the extent to which system of care is cost effective.

The Commission shall also examine the following principles that are associated with a system of care and determine whether to recommend the adoption of a State policy that reflects these principles:

a. Services for children should promote success, safety and permanence.

b. Services should be child- and family-centered giving priority to keeping children with their families, in their home school and community.

c. Services should actively promote early identification and intervention.

d. Services should be designed to protect the rights of children.

e. Services shall be integrated and comprehensive, addressing the child's physical, educational, social, and emotional needs through a single Child and Family Team.

f. Services shall be outcomes-accountable and tied to a unified Child and Family Plan.

g. Agency resources and services shall be shared and coordinated.

h. Services shall be provided as close to home as appropriate in the least restrictive setting consistent with what is known to be effective.

i. Services shall be culturally competent.

j. Services shall address the unique strengths, needs and potential of each child and family, and shall be sufficiently flexible to meet highly individualized child and family needs.

k. Management of the child serving system is a responsibility shared among all public and private child-serving agencies that should be held collectively accountable for outcomes.

In reviewing these or any other principles, the Commission shall determine whether they articulate goals that are measurable and if not, determine whether they could be modified to reflect measurable goals.

BILL DRAFT:
Coordination of Children's Services/Study

BILL ANALYSIS

Committee:	Joint Legislative Oversight Committee on MH/DD/SAS	**Introduced by:**	
Date:	January 26, 2005	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	2005-RCz-9[v.7]		

SUMMARY: ***The bill creates Chapter 143C entitled "Coordination of Children's Services". It states that the intent of the General Assembly is to improve services to children, support collaboration between agencies, make more effective use of resources, and streamline service delivery. It also states that child-serving agencies share responsibility and accountability for improving outcomes for children and families. In addition, the bill also creates a children's services work group housed in the Department of Administration, a work group for legislative staff assigned to child servicing agencies and subject areas, and study commission on the coordination of children's services.***

CURRENT LAW: There are a number of entities created at the State level that are charged with overseeing services to children, youth and families. However, these groups tend to be charged with issues related to specific populations or services, such at prevention of juvenile delinquency (the Governor's Advisory Council on Juvenile Justice and Delinquency Prevention), early childhood development (Partnership for Children), or education (the Education Cabinet). There are also numerous local collaborative entities that reflect their State-level counterparts, such as the Juvenile Crime Prevention Councils. However, there is no governmental entity charged with the over-arching responsibility of coordinating children's services across age, agencies and disciplines.

The need for coordination and collaboration is recognized and is being implemented by many agencies under Memorandums of Agreement or Memorandums of Understanding (MOAs or MOUs). For example, the Department of Health and Human Services (DHHS), the Department of Public Instruction (DPI), the Department of Juvenile Justice and Delinquency Prevention (DJJDP), and the Administrative Office of the Courts (AOC) have entered into a MOA regarding the Comprehensive Treatment Services Program (CTSP) for children at-risk for institutionalization or other out of home placement. The MOA is required by law and must exist before CTSP funds can be made available (S.L. 2001-424, Sec. 21.60.(d)). Similarly, DHHS may not allocate CTSP funds at the local level until an MOA between the local counterparts of these agencies is in place. MOAs and MOUs also exist between DPI and DHHS regarding the provision of services to exceptional children, between DJJDP and local mental health programs regarding residential services to at-risk children in need of mental health and substance abuse treatment, and between local local mental health programs and

Section 3 directs the Directors of the Bill Drafting, Research, and Fiscal Research Divisions of the General Assembly to create a children's services work group comprised of the legislative staff who are assigned to subject areas or agencies involving child-serving programs administered by DHHS, DJJDP, DPI, and AOC. The work group shall monitor the work of the agency work group created under Section 2 of the bill, provide information to legislators regarding the recommendations of that work group, and create a mechanism for better coordination and information regarding children's services among legislative staff. The legislative staff children's services work group will expire upon the convening of the 2009 General Assembly.

Section 4 creates the Coordination of Children's Services Study Commission (Commission). The Commission shall consist of 18 members, 9 appointed by the President Pro Tempore of the Senate and 9 appointed by the Speaker of the House of Representatives.

The President Pro Tempore's appointees will include five legislators, at least on of whom also serves on the Senate Health and Human Services Appropriations Subcommittee, at least one of whom also serves on the Senate Education Committee, at least one of whom also serves on the Senate Health Committee, and at least one of whom also serves on a Senate Judiciary Committee. The four public members appointed by the President Pro Tempore will include a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a member of a local board of education, and a member of a board of county commissioners.

The Speaker's appointees will include five legislators, at least on of whom also serves on the House Health and Human Services Appropriations Subcommittee, at least one of whom also serves on the House Education Committee, at least one of whom also serves on the House Health Committee, and at least one of whom also serves on a House Judiciary Committee. The four public members appointed by the Speaker include a district court judge, a member of a local collaborative body, a private sector service provider, and a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure.

The purpose of the Commission is to study and recommend changes to improve collaboration and coordination between agencies that provide services to children, youth and families with multiple service needs, including mechanisms for establishing clear State leadership, consistent policy direction, and increased accountability at the State and local level. The Commission shall:

- look at conflicting and overlapping collaborative entities and make recommendations regarding their consolidation, reorganization or elimination;

APPENDIX VI

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COALITION 2001 FUNDING REQUEST

2005 SESSION OF THE N.C. GENERAL ASSEMBLY

January 2005

I.	TRUST FUND REQUEST	$20,000,000
	a. Crisis Services	
	b. Children's Services	
	c. Bridge/Start-up Funding to Develop Community Capacity to Those in the target Population.	
II.	RECURRING APPROPRIATION REQUEST	$134, 000,000
	a. Supported Employment/Long-term Vocational Support Services	$6,000,000
	b. Crisis Services	$5,000,000
	c. Children's Services	$8,500,000
	d. Community Capacity Development for Those in the Target Population Who are Waiting for Services	$90,000,000
	e. Residential Services	$19,000,000
	f. Specialty Appropriation Requests (Deaf MI, DDTI, Family Support)	$5,500,000

III. MEDICAID MATCH STATEMENT

IV. INFLATIONARY ADJUSTMENT STATEMENT

COALITION 2001

2005 FUNDING REQUEST TO THE NC GENERAL ASSEMBLY

Coalition 2001 is composed of 48 statewide, not-for-profit organizations representing families, consumers, advocates and providers that work in the areas of mental health, developmental disabilities, and substance abuse services. This Coalition has been in existence since 1991 and has helped bring awareness of and funding to the community MH/DD/SA system in North Carolina. The 2005 budget request continues the Coalition's appropriations advocacy to assure provision of services to the hundreds of thousands of North Carolinians affected by these disabilities.

Coalition 2001 is seeking to address funding needs that are both one-time and recurring in nature and that deal with the impact of the Olmstead decision, Medicaid, and inflationary issues. Additionally, Coalition 2001 has researched the number of individuals affected by these requests, their service needs and their accompanying economic impact, and has developed this funding request based on this research. Coalition 2001 has also taken into account the issue of MH/DD/SAS reform as a major component of its funding priorities.

Coalition 2001, whose motto is "It's just good business", seeks to fulfill the promise that the state of North Carolina has made to its citizens that experience mental illness, developmental disabilities, and substance abuse problems by addressing the major areas of need across a broad spectrum of services at a time of great change.

I. APPROPRIATION REQUEST FOR TRUST FUND/NON-RECURRING ITEMS $20,000,000

The following are three umbrella areas that are critical to the success of reform, and the success of individuals affected by mental illness, developmental disabilities, and substance abuse problems.

A. **Crisis Services** - including those that are mobile and community based along a continuum that serves both children and adults affected by these disabilities in order to prevent institutionalization.

B. **Children's Services** - These vital services are needed throughout a system of care approach for children that face these three disability areas. These are services that are preventative, provide for early intervention, and are community focused.

C. **Bridge/Start-Up Funding for Community-based Services to Those in the Target Population Who are Unserved or Underserved** - These crucial programs and services are essential for moving individuals into the community in accordance with the Olmstead decision and for the success of MH/DD/SAS reform and for the well being of adults and children that experience mental illness, developmental disabilities, and substance abuse problems throughout the state. This also includes essential training for providers, LMEs, family members, and consumers.

citizens who are waiting for initial services to begin, as well as thousands of others that are waiting for additional services. Funds would go to services such as intensive outpatient and comprehensive outpatient treatment programs for those in the area of substance abuse, ACT, community support and interdisciplinary dual diagnosis teams for mental health. Also, CAP/ DD Medicaid funds are needed to allow North Carolina to draw down additional funds to reduce the DD waiting lists. Additionally, DD waiting list funds are needed for those that are not waiver program eligible.

E. Residential Services **$19,000,000**

This key area is designed to provide support and programming to allow individuals to stay in their own home within their own community, and to keep them from ending up in a more costly, long-term care or state facility which is often a great distance away from their home.

1. Housing Support - This crucial funding is to provide needed operational dollars to support a range of group and supportive living programming at the community level for persons affected by mental illness, developmental disabilities and/or substance abuse problems. An example of where this support would be utilized is DDA group homes. DDA group homes provide a stable living environment for individuals with developmental disabilities in communities throughout North Carolina. Most of these homes were originally built utilizing HUD funds with a legislative appropriation for services. The service funds have been eroding, compromising the ability for people to successfully live in communities. This funding will allow for people to continue to live successfully in these homes. ($15,000,000)

2. Special Assistance/Rental Assistance - This appropriation request is to expand the innovative pilot program for special assistance and to add additional rental assistance funding on top of that for others who would not be eligible to receive special assistance. ($4,000,000)

F. Specialty Appropriation Requests **$5,500,000**

1. Deaf/MI funds: This $2,500,000 will allow the state to continue to be in compliance with its 504 B Settlement Agreement with the NC Association for the Deaf. It also would continue to provide crucial community based services to the resident of N.C. who experience mental illness and are also deaf by providing a full range of services including out-patient, psychosocial rehabilitation, ACTT, case management, and more with the proper use of interpreting/translating services.

2. DDTI Funds: This $1,000,000 would allow the Developmental Disabilities Training Institute to continue to provide core training for staff on DD Best Practice. It would also allow DDTI to provide stipends to allow staff to attend the training more easily.

3. First in Families/Family Support: This $2,000,000 request would assist First in Families, which is North Carolina's family support program for families with people with developmental disabilities. These programs, which are now in many of the LMEs, are for relatively small, one time grants to support families to keep their

COALITION 2001 MEMBER ORGANIZATIONS

January 2005

The Arc of North Carolina
Addiction Professionals of North Carolina
Alcohol/Drug Council of North Carolina
Autism Society of NC
Brain Injury Association of NC
Carolina Legal Assistance
Coalition for Persons Disabled by Mental Illness
Developmental Disabilities Consortium
Durham Council on Alcohol and Drug Abuse
Easter Seals UCP North Carolina
Epilepsy Foundation of NC
Family Alternatives, Inc.
Governor's Advocacy Council for Persons with Disabilities
Governor's Institute on Alcohol & Substance Abuse
Mental Health Association – NC
Mental Retardation Association of NC
NAMI – NC
National Association of Social Workers – NC Chapter
NC Assistive Technology Project
North Carolina Association for Addiction Residential Facilities
North Carolina Association for Behavioral Analysis
North Carolina Association for Behavioral Health Care
North Carolina Association for Marriage & Family Therapy
North Carolina Association Rehabilitation Facilities
North Carolina Association of the Deaf
North Carolina Child Advocacy Institute
North Carolina Community Sentencing Association
North Carolina Community Support Providers Council
North Carolina Council for Community Programs
North Carolina Council on Developmental Disabilities
North Carolina Deaf-Blind Associates
North Carolina Depression and Bi-Polar Support Alliance
North Carolina Employee Assistance Professionals Association
North Carolina Guardianship Association
NC Interagency Coordinating Council
North Carolina International Association of Psychosocial Rehabilitation Services
North Carolina Mental Health Consumers' Organization
North Carolina Nurses Association
North Carolina Psychiatric Association
North Carolina Psychological Association
NC Psychological Foundation
North Carolina Recreation Therapy Association
NC TASH
Partnerships in Assistive Technology
Self Advocates of NC
Substance Abuse Federation
VOICES for Addiction Recovery